86 - 1023 (1)

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

BLUE CROSS ASSOCIATION and BLUE CROSS/BLUE SHIELD OF GREATER NEW YORK,

Petitioners,

– and –

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent,

– against –

GROUP HEALTH INCORPORATED,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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6 pp

QUESTIONS PRESENTED

1. Is an order entered prior to trial rejecting defendants' claim of official immunity from suit at common law based on discharge of their responsibility as fiscal intermediary under Medicare a final collateral order appealable to the Court of Appeals?

2. Can considerations of judicial economy override the final collateral order doctrine and thus deprive defendants of their right to appeal, prior to trial, the denial of their claim to official immunity from such suit?

PARTIES TO THE PROCEEDING

1. *Defendants.*

Petitioners (defendants) are Blue Cross/Blue Shield of Greater New York, now known as Empire Blue Cross and Blue Shield, Inc. ("Blue Cross"), and the Blue Cross Association, now known as the Blue Cross and Blue Shield Association (the "Association"). Blue Cross is a not-for-profit health services corporation, organized and operating pursuant to Article 43 of the New York State Insurance Law, that provides hospital and health related benefits to some 10 million New Yorkers. It also serves as a "fiscal intermediary" and agent of the United States under the federal program of health insurance for the aged and disabled established pursuant to 42 U.S.C. §§ 1395, *et seq.* (1982) (the "Medicare" program). The Association is incorporated under the Illinois General Not-For-Profit Corporation Act and has a membership that includes Blue Cross as well as sixty-seven other Blue Cross Plans operating throughout the United States.[1]

2. *Intervenor-Defendant.*

United States Department of Health and Human Services ("HHS") (defendant) administers the Medicare Program. HHS successfully intervened in the district court as a party defendant on the grounds that a judgment in favor of plaintiff could render HHS liable to defendants for indemnification and would result in the circumvention of administrative review procedures that have been established under the Medicare Program.

3. *Plaintiff.*

Respondent (plaintiff) Group Health Incorporated ("GHI"), like Blue Cross, is a not-for-profit corporation organized and existing pursuant to Article 43 of the New York State Insurance Law. GHI not only underwrites health coverage, but for some

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[1] At all relevant times, the Association was authorized by contract with the federal Health Care Financing Agency to act as fiscal intermediary. With the approval of said Agency, the Association subcontracted to Blue Cross its duties

(Footnote Continued)

time provided hospital services to persons covered by Blue Cross as well as by Medicare via Hillcrest General Hospital ("Hillcrest"), which GHI purchased on February 28, 1974 and sold six years later on February 29, 1980. (JA 189.)[2] For these years, Hillcrest elected to receive its reimbursement under Medicare through a fiscal intermediary and nominated Blue Cross for that purpose. It is advice rendered to GHI by Blue Cross as fiscal intermediary and concerning reimbursement under Medicare that comprises the basis for this action as well as for defendants' claim to official immunity as federal agents.

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as Part A fiscal intermediary within the Blue Cross service area. That area comprises the seventeen counties that include New York City and its environs as well as nine additional counties ranging from Albany east and north to the Canadian border.

[2] Citations that begin "JA" refer to pages in the Joint Appendix.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Petitioners Blue Cross and the Association pray for a writ of certiorari to review the decision of the United States Court of Appeals for the Second Circuit, entered June 20, 1986. That Court dismissed defendants' appeal from an order of the United States District Court for the Southern District of New York denying summary judgment on their defense of official immunity. A petition for rehearing was denied on September 29, 1986. The Court of Appeals held that although petitioners had raised a nonfrivolous claim that as fiscal intermediaries under Medicare they were immune from suit based on actions taken within their delegated authority, it nevertheless lacked

jurisdiction to hear their appeal. Defendants' claim of official immunity was deemed unfit for immediate appellate review because (a) the issue of immunity was not collateral to the merits of the underlying action, and (b) the interest of judicial economy would be best served by declining jurisdiction and thus allowing this action to proceed together with GHI's independent action against the United States under the Federal Tort Claims Act ("FTCA"), *Group Health Incorporated v. United States of America and Otis R. Bowen*, 84 Civ. 2917 (PKL).

OPINIONS BELOW

The opinion of the Court of Appeals is reproduced in Appendix A (A-1 to A-13). The opinion of the district court is reproduced in Appendix B (B-1 to B-24). Citations to such opinions are to the relevant pages in the Appendices.

JURISDICTION

The judgment of the Court of Appeals was entered on June 20, 1986. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1) (1982).

STATEMENT OF THE CASE

1. *Factual Background.*

GHI brought suit against Blue Cross and the Association in state court alleging common law negligence and tortious misrepresentation. Blue Cross and the Association removed the case from state court pursuant to 28 U.S.C. § 1442(a)(1) (1982), which permits removal by "[a]ny officer of the United States or any agency thereof, or person acting under him, for any act under color of such office . . . ." A motion by GHI to remand was denied by order filed June 15, 1984. The basis of GHI's complaint is that, as fiscal intermediary, Blue Cross erroneously advised GHI that certain interest payments that were to be made by Hillcrest on monies that GHI supposedly loaned Hillcrest to pay for its purchase would be reimbursable as an expense under Medicare. (JA 223-24.)

A. *The Medicare Program.*

Part A of Medicare provides hospital insurance coverage for individuals who qualify for monthly Social Security benefits as well as for certain disabled persons. 42 U.S.C. § 1395c(a) (1982). The cost of providing Part A services is principally borne by the Federal Hospital Insurance Trust Fund, created on the books of the Treasury of the United States and funded by Social Security taxes. 42 U.S.C. § 1395i (1982). Pursuant to 42 U.S.C. § 1395cc(a)(1)(A) (1982), Part A providers agree not to charge individuals covered by Medicare for the inpatient services rendered to them. Instead, the providers accept reimbursement from the trust fund, in amounts calculated under Medicare regulations by the Health Care Financing Administration ("HCFA") or, at the option of the provider, by private organizations under contract with HCFA. These private parties – known as fiscal intermediaries – act as agents of HHS in administering the Medicare program. 42 U.S.C. § 1395h(a) (1982). At all times relevant, Hillcrest chose Blue Cross as its intermediary.

B. *The Role of Fiscal Intermediary.*

On the one hand, HCFA remains responsible for policy decisions involving the Medicare Program, and "HCFA is the real party of interest in any litigation involving the administration of the program." 42 C.F.R. § 421.5(b) (1985); at the same time, however, the fiscal intermediary, pursuant to 42 U.S.C. § 1395(h) (1982) and applicable regulations, 42 C.F.R. Part 421 (1985), has broad discretion to administer Medicare on behalf of HHS.

Initially, the fiscal intermediary is responsible "for the determination . . . of the amount of the payments required . . ." to be made to the provider pursuant to regulation. 42 U.S.C. § 1395h(a). These call for reimbursement for the reasonable costs of providing hospital services to Medicare beneficiaries. 42 U.S.C. § 1395f(b) (1982). Reasonable costs include all of a provider's necessary and proper expenses, and interest expense, under prescribed circumstances, is a cost which may be reimbursable. 42 C.F.R. § 405.419 (1985).

The fiscal intermediary is also responsible for making those payments from federal funds. Thus a fiscal intermediary is obliged to "establish a basis for interim payments to each provider . . ." 42 C.F.R. § 405.405(a) (1985) and make those interim payments to a provider no less often than monthly on the basis of the provider's unaudited interim cost reports. 42 U.S.C. § 1395g (1982); 42 C.F.R. §§ 405.405(c) (1985), 405.454 (1985).

After the end of each year, providers are required to file audited cost reports. 42 C.F.R. § 405.453(f) (1985). Where any such cost report reveals that reimbursement claimed is either inadequate or excessive, the fiscal intermediary is directed to make suitable corrective adjustment. 42 U.S.C. § 1395x(v)(1)(A)(ii) (1982); 42 C.F.R. §§ 405,405(b) (1985), (c), 405.454(a) (1985), (f) (1985). If the provider is not satisfied with the fiscal intermediary's determination, it may request a hearing before the Provider Reimbursement Review Board, whose decision is subject to review by the Secretary and subsequently in a civil action commenced in the district court. *See* 42 U.S.C. § 1395oo (1982).

Finally, and most importantly for purposes of this Petition, a fiscal intermediary is obliged to assist providers with questions and problems they may encounter concerning Medicare reimbursement. Thus, 42 C.F.R. § 405.406(b) (1985) mandates that:

> [i]n the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be an important source of consultative assistance to providers and will be available to deal with questions and problems on a day-to-day basis.

C. *The Underlying Action.*

It was in accord with this obligation that, following purchase of Hillcrest by GHI, and in response to GHI's inquiry, Blue Cross as fiscal intermediary advised that certain interest payments that were to be made by Hillcrest, on a loan supposedly advanced to Hillcrest by GHI, would be reimbursable to Hillcrest under Medicare. (JA 224.) When its audit of Hillcrest thereafter revealed that no loan from GHI had ever been booked and no interest

actually paid (JA 231), Blue Cross consulted HCFA and was advised that Medicare reimbursement for alleged interest payments was not proper on the ground "that no loan was ever made." (JA 227.) Blue Cross thereafter disallowed reimbursement under Medicare for the supposed interest payments. Blue Cross' original advice as to whether any such interest would be reimbursable is the basis for plaintiff's suit, and the fact that such advice was rendered as required of a Medicare intermediary, comprises the basis for defendants' official immunity claim.

Disallowance of the supposed interest payments was subsequently upheld by the Provider Reimbursement Review Board ("PRRB") which found, *inter alia*, that

> [t]he record clearly shows that during the periods in question interest payments were not made by Hillcrest to GHI. In fact payments were not made until 1979. It is important to note that these payments were preceded by cash transfers from GHI to Hillcrest.

(JA 233.) The determination of the PRRB became the final decision of the Secretary on November 18, 1980.[3] (JA 14, 229-35.) GHI appealed this decision to the United States District Court for the Southern District of New York. The district court granted the motion of the defendant Secretary for summary judgment. *Group Health Incorporated v. Schweiker*, No. 80 Civ. 6163 (S.D.N.Y. March 22, 1982), *aff'd*, 742 F.2d 1434 (2d Cir. 1983), *cert. denied*, 467 U.S. 1225 (1984). In an order not for publication, the United States Court of Appeals for the Second Circuit affirmed the decision of the district court, and this Court denied review via certiorari.

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[3] GHI has also appealed the disallowance as applied to Hillcrest's 1977, 1978, 1979 and 1980 Medicare reimbursement. The issues to be decided are identical, and only the amounts involved are different (though not in dispute). In a decision dated March 27, 1984, the PRRB again upheld the disallowance, this time with respect to 1977. GHI has sought review of that decision as part of its Federal Tort Claims Act suit against the government, *infra*, at 6. The final PRRB proceeding commenced by GHI, which applies to 1978, 1979 and 1980, is apparently dormant.

Having failed in its direct attack on the Secretary's disallowance of Medicare reimbursement for interest allegedly paid, GHI launched this action against Blue Cross and the Association alleging five separate claims pertaining to Medicare reimbursement, all based solely on common law. Though variously phrased as a breach of duty by Blue Cross to consult with HHS prior to its advice, misrepresentation that the alleged interest payments would be reimbursable, and misrepresentation of authority to render the advice as well as two derivative claims against the Association for failure to supervise its agent, all rest solely on the reimbursement advice Blue Cross rendered as fiscal intermediary. That advice was embodied in a single letter from Blue Cross to GHI (JA 224) which is annexed to the complaint.* Shortly after commencing this proceeding, GHI also instituted an independent action against the United States of America and Otis R. Bowen, Secretary of Health and Human Services, under the Federal Tort Claims Act, alleging, *inter alia*, that Blue Cross was negligent in dealing with GHI and that HHS was negligent in supervising Blue Cross, its agent.

The issue before the district court in the present action was whether Blue Cross and the Association were entitled to summary judgment on their claim of official immunity since the suit is based solely on actions taken in the discharge of duties delegated by the government to them as fiscal intermediaries under Medicare. The district court answered this question in the negative and petitioners appealed. The Court of Appeals dismissed the appeal for lack of appellate jurisdiction. Thus, the question for review by this Court would be whether postponing until after trial petitioners' appeal on their claim of official immunity effectively deprives them of that protection from trial to which they are entitled.

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* Accordingly, no factual dispute can be said to exist as to those questions typically relevant to inquiry on official immunity — the names and positions of either the source or recipient of the advice, the date and manner of its transmittal, the content of the advice or the context in which it was provided.

2. *The Opinion of the District Court.*

The district court denied petitioners' motion for summary judgment on their claim of official immunity[5] on the grounds that – as a matter of law – fiscal intermediaries cannot be considered government officials for official immunity purposes. (B 14-20.) The district court further stated that while it was unnecessary to decide whether Blue Cross was acting within the scope of its authority, a factual dispute existed with respect to the exact scope of authority of the fiscal intermediary. (B 19-20.)

3. *The Opinion of the Court of Appeals.*

The Court of Appeals dismissed the appeal, holding that "[a]lthough defendants have alleged a nonfrivolous claim that fiscal intermediaries in the Medicare program are entitled to official immunity, *see San Filippo v. U.S. Trust Co. of New York, Inc.*, 737 F.2d at 254-55, this appeal must be dismissed [because] [d]efendants' claim of absolute immunity is not within 'that small class which finally determine claims of right separable from, and collateral to, rights asserted in the action . . . .' *Cohen*, 337 U.S. at 546." (A 12.) Such dismissal rested on the holding that the immunity question was not collateral from the merits, particularly whether Blue Cross acted within the scope of its authority. (A 12.) Beyond that, the Court of Appeals concluded that to force GHI to litigate its claims against Blue Cross and the government separately would result in an inefficient use of judicial resources because of "the closely intertwined immunity issues" in the two cases. (A 12-13.)

REASONS FOR GRANTING THE WRIT

"This Court consistently has recognized that government officials are entitled to some form of immunity from suits for civil damages." *Nixon v. Fitzgerald*, 457 U.S. 731, 744 (1982). Thus, as recounted in *Nixon*, it was almost a century ago that:

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[5]Petitioners' motions for summary judgment on the grounds of sovereign immunity and on the merits were similarly denied by the district court.

> [i]n *Spalding v. Vilas*, 161 U.S. 483 (1896), the Court considered the immunity available to the Postmaster General in a suit for damages based upon his official acts. Drawing upon principles of immunity developed in English cases at common law, the Court concluded that "[t]he interests of the people" required a grant of absolute immunity to public officers. *Id.* at 498. In the absence of immunity, the Court reasoned, executive officials would hesitate to exercise their discretion in a way "injuriously affect[ing] the claims of particular individuals," *id.*, at 499, even when the public interest required bold and unhesitating action.

Id. at 744-45.

In short, this Court has made clear that government officials, regardless of rank or allegations of bad faith, are absolutely immune from suits at common law[6] based on acts within their authority; as this Court put it in *Barr v. Matteo*, 360 U.S. 564, 574-75 (1959), sustaining a federal official's "plea of absolute privilege in defense of the alleged libel published at his direction," the sole "fact that the action here taken was within the outer perimeter of petitioner's line of duty is enough to render the privilege applicable, despite the allegations of malice in the complaint . . . ." *See Butz v. Economou*, 438 U.S. 478 (1978).

POLICY BASES FOR THE DOCTRINE OF OFFICIAL IMMUNITY

Barr v. Matteo also explicates the rationale for absolute immunity and emphasizes its intended protection for government officials, of whatever rank or title, against suits at common law based on performance of their duties:

> [i]t has been thought important that officials of government should be free to exercise their duties unembarrassed by the fear of damage suits in respect of acts done in the course of those duties — suits which would

[6] To repeat, GHI's complaint asserts only common law claims and alleges no statutory or constitutional claims.

> consume time and energies which would otherwise be devoted to governmental service and the threat of which might appreciably inhibit the fearless, vigorous and effective administration of policies of government.

360 U.S. at 571. *See Gregoire v. Biddle*, 177 F.2d 579, 581 (2d Cir. 1949), *cert. denied*, 339 U.S. 949 (1950) (per. L. Hand, J.).

THE EFFECTIVE ADMINISTRATION OF MEDICARE REQUIRES THAT OFFICIAL IMMUNITY PROTECT NOT ONLY GOVERNMENT EMPLOYEES, BUT ALSO GOVERNMENT AGENTS SUCH AS FISCAL INTERMEDIARIES

Had the very same advice on which this complaint rests been rendered by an employee of the United States, none question that such employee would be immune from suit at common law arising out of that advice. The same should follow here: as agents of HHS in the administration of the complex federal Medicare program, Blue Cross should likewise be free to claim official immunity from any such suit.

Official immunity does not depend on the official's status or title but on the function he performs. So it is that "the guide in delineating the scope of the rule which clothes the official acts of the executive officer with immunity" is "not the title of his office but the duties with which the particular officer sought to be made to respond in damages is entrusted — the relation of the act complained of to 'matters committed by law to his control or supervision.' " *Barr v. Matteo*, 360 U.S. at 573-74 (quoting *Spalding v. Vilas*, 161 U.S. 483, 498 (1896)). *See Doe v. McMillan*, 412 U.S. 306, 320 (1973). Thus, official immunity has been held to protect not only federal employees, of lesser as well as greater rank, but also private parties when sued for their acts as federal agents. *See Bushman v. Seiler*, 755 F.2d 653 (8th Cir. 1985); *Becker v. Philco Corp.*, 372 F.2d 771 (4th Cir.), *cert. denied*, 389 U.S. 979 (1967).

Beyond question, as the courts have consistently held:

> Medicare fiscal intermediaries . . . act as agents at the sole direction of the Secretary of Health, Education and Welfare . . . .

Peterson v. Weinberger, 508 F.2d 45, 51 (5th Cir.), *cert. denied*, 423 U.S. 830 (1975) (footnote omitted). *Accord Heckler v. Community Health Services*, 467 U.S. 51, 63-65 (1984); *Matranga v. Travelers Insurance Co.*, 563 F.2d 677 (5th Cir. 1977); *Pine View Gardens, Inc. v. Mutual of Omaha Insurance Co.*, 485 F.2d 1073 (D.C. Cir. 1973). As an agent of the federal government, a fiscal intermediary, like a government employee, should be entitled to official immunity from suit at common law based on actions not "manifestly or palpably beyond his authority." *Spalding v. Vilas*, 161 U.S. 483, 498 (1896).

Particularly so in light of the vital role played by fiscal intermediaries in the conduct of the multi-billion dollar Medicare program. As the brief of the United States Department of Health and Human Services before the Court of Appeals put it (at p. 23):

> it is essential to the efficient and effective administration of the Medicare program that fiscal intermediaries be immunized from suits arising out of erroneous decisions on reimbursement questions . . . . HHS depends on its fiscal intermediaries to resolve reimbursement issues and to provide consultative assistance to providers. If fiscal intermediaries are unable to perform these functions without fear of litigation and potential liability for mistakes, they might become overly cautious, refer all questions to HHS or withdraw from the program. . . . In light of the immensity of and the numerous administrative duties involved in the Medicare program, *see National Ass'n of Home Health Agencies v. Schweiker*, 690 F.2d 932, 943 (D.C. Cir. 1982), *cert. denied*, 459 U.S. 1205 (1983), such consequences could have a drastic impact on the program and, accordingly, the public interest.

Against this background, the decision of the Court of Appeals to dismiss the appeal should be reviewed.

I

The Court of Appeals' Rationale for Dismissing The Appeal Conflicts With This Court's Decisions and Presents an Important Question of Federal Law Which Should Be Settled By This Court.

This Court has held on more than one occasion that orders denying summary judgment on claims of absolute or qualified immunity are immediately appealable as collateral final orders. *See, e.g., Mitchell v. Forsyth*, 105 S. Ct. 2806 (1985) (Attorney General's qualified immunity); *Nixon v. Fitzgerald*, 457 U.S. 731 (1982) (the President's absolute immunity); *Helstoski v. Meanor*, 442 U.S. 500 (1979) (Speech and Debate Clause); *Abney v. United States*, 431 U.S. 651 (1977) (Double Jeopardy Clause).

As *Nixon* explained (457 U.S. at 742):

> [u]nder the "collateral order" doctrine of *Cohen v. Beneficial Industrial Loan Corp.*, 337 U.S. 541 (1949), a small class of interlocutory orders are immediately appealable to the court of appeals. As defined by *Cohen*, this class embraces orders that "conclusively determine the disputed question, resolve an important issue completely separate from the merits of the action and [are] effectively unreviewable on appeal from a final judgment." *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 468 (1978). . . . At least twice before this Court has held that orders denying claims of absolute immunity are appealable under the *Cohen* criteria.

The underlying rationale of all of these cases is that the denial of a claim of either absolute or qualified immunity is both collateral and final within the meaning of *Cohen v. Beneficial Industrial Loan Corp.*, 337 U.S. 541 (1949). Such well settled law the Court of Appeals misread in two crucial respects by concluding

– First, that the issue of immunity was not collateral to the underlying claim, despite this Court's holding to the

contrary in *Mitchell v. Forsyth*, 105 S. Ct. 2806 (1985); and

– Second, that the immunity question was not solely a question of law, despite this Court's holding to the contrary in *Nixon v. Fitzgerald*, 457 U.S. 731, 743 n. 23 (1982).

Thus, the decision of the Court of Appeals significantly undermines the protection afforded by absolute official immunity from the rigors of trial for acts of federal agents in performance of their federal duties – here fiscal intermediaries under Medicare – and should be reviewed.

1. *The Court of Appeals' Conclusion That the Immunity Issue Is Not Collateral Conflicts With Decisions of This Court.*

The Court of Appeals concluded that the immunity issue was not collateral because it could not be decided without addressing GHI's underlying claims on the merits. In *Abney v. United States*, 431 U.S. 651 (1977), however, this Court made clear that a claim of immunity is, by its very nature, collateral to and separable from the underlying issues for trial. This is so because a defendant claiming official immunity challenges – not the merits of the underlying action – but only plaintiff's right to hale him into court.

Here, as in *Abney*, "the very nature of" defendants' immunity claim "is such that it is collateral to, and separable from, the principal issue at the accused's impending . . . trial." (*Id.* at 659.) – What advice did defendants render? Was it right or wrong? In any event, did plaintiff in fact, and could plaintiff justifiably, rely on such advice to his detriment – rendered as it was after (rather than before) plaintiff's acquisition of its hospital and by a fiscal intermediary whom plaintiff, itself an intermediary under Medicare Part B, well knew had no final say in the matter? *See Heckler v. Community Health Services*, 467 U.S. 51 (1984). Again, as in *Abney*, defendants now challenge – not the merits of plaintiff's claim – but instead "the very authority of the . . . [plaintiff] to hale him into court to face trial." *Id.* at 659 (citation omitted).

Mitchell v. Forsyth, 105 S. Ct. 2806 (1985), finally disposes of the Court of Appeals' reasoning on this score. This Court's beginning point in *Mitchell* was the basic that

> denial of a substantial claim of absolute immunity is an order appealable before final judgment, for the essence of absolute immunity is its possessor's entitlement not to have to answer for his conduct in a civil damages action.

105 S. Ct. 2806 at 2815.[7]

Building on this conclusion, *Mitchell* went on to resolve the very issue on which the Court of Appeals ruled just to the opposite:

> it follows from the recognition that qualified immunity is in part an entitlement not to be forced to litigate the consequences of official conduct that *a claim of immunity is conceptually distinct from the merits of the plaintiff's claim that his rights have been violated.* . . . In holding . . . issues of absolute immunity to be appealable under the collateral order doctrine, see *Abney v. United States* . . . *Helstoski v. Meanor* . . . *Nixon v. Fitzgerald* . . . *the Court has recognized that a question of immunity is separate from the merits of the underlying action for purposes of the Cohen test even though a reviewing court must consider the plaintiff's factual allegations in resolving the immunity issue.*

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[7] This protection from the travails of trial *Mitchell* extended to claims of qualified as well as absolute official immunity "so long as . . . [the claimant, federal officials or agents] do not violate 'clearly established statutory or constitutional rights of which a reasonable person would have known.' " (*Id.* at 2814, quoting *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982)). Defendants here claim "absolute" — not "qualified" — official immunity from suit at common law as federal agents sued because of advice, even if such be deemed erroneous, that it was their federal responsibility to render. *See* 42 C.R.F. § 405.406(b) (1985). Immunity applies even if such advice was proved wrong or maliciously motivated. *See Barr v. Matteo*, 360 U.S. 564, 575 (1959).

(*Id.* at 2816-17, citations omitted, footnote omitted.) (Emphasis added.)

2. *There Is No Dispute of Material Fact That Precludes Appellate Review In This Case.*

The Court of Appeals reasoned that the immunity issue is not solely a matter of law because a disputed question of fact exists as to whether Blue Cross acted within the scope of its authority. Again, this conclusion conflicts with this Court's holding that the immunity question is one of law and does not become a question of fact sufficient to defeat jurisdiction merely because the plaintiff alleges that the defendant official exceeded his authority.

Thus, in *Nixon v. Fitzgerald*, 457 U.S. 731 (1982), the Court held that notwithstanding plaintiff's allegations that the President had exceeded the scope of his authority, the denial of the President's immunity claim was immediately appealable and that "the immunity question is a pure issue of law." *Id.* at 743 n.23. The Court's focus of inquiry on the immunity issue was whether the actions taken by the President were within the "outer perimeter" of his constitutional and statutory authority. *See Barr v. Matteo*, 360 U.S. 564, 575 (1959). Here too, the sole focus of inquiry should be whether "[t]he conduct in question [providing reimbursement advice to GHI is] more or less connected to 'the general matters committed by law to [Blue Cross'] control or supervision' and not 'manifestly or palpably beyond [its] authority.' " *Ricci v. Key Bancshares of Maine, Inc.*, 768 F.2d 456, 462 (1st Cir. 1985) (quoting *Spalding v. Vilas*, 161 U.S. 483, 498 (1896)).

GHI sought Medicare reimbursement advice from Blue Cross, which was admittedly acting as GHI's fiscal intermediary. Medicare regulations, to repeat, obliged Blue Cross as fiscal intermediary to "be an important source of consultative assistance to providers and . . . be available to deal with questions and problems on a day-to-day basis." 42 C.F.R. § 405.406(b). In accordance with these obligations, Blue Cross responded to GHI by letter with the advice which forms the basis of this action,

regarding the reimbursability under Medicare of what was represented to be interest expense by Hillcrest. (JA 224.)

In this context, there can be no question of fact that defendants have been sued

> – for rendering "consultative assistance,"
>
> – concerning "the interpretation and application of the principles of [Medicare] reimbursement,"
>
> – at the instance of a Medicare provider, Hillcrest.

Beyond fair dispute, therefore, Blue Cross is sued for action within its authority – rendering advice as it was obliged to do as a Medicare intermediary – and its conduct falls within the "outer perimeter" of its authority as an agent of the federal government.

II

The Court of Appeals Erred When It Needlessly Sacrificed the Protection of Official Immunity on the Altar of Judicial Economy.

The focus of the Court of Appeals' concern for judicial economy is the separate FTCA action commenced by GHI against the government to which Blue Cross and the Association are not parties. On its view that the two cases present " 'but a single controversy,' " (A 12), the Court of Appeals states (A 12-13):

> judicial economy suggests that all of the closely intertwined immunity issues – including those raised but not now before us under the FTCA – proceed together in the district court before the same judge. Assuming a trial, the jury and non-jury actions doubtless can be tried in one consolidated action with joint discovery and appropriate allocation of decision-making authority so as to result in one final judgment that will be effectively reviewable.

On this score, the Court of Appeals would stand on its ear the bases for official immunity; it would leave to plaintiffs, the very persons against whose litigation forays official immunity was meant to protect government agents, the power to determine whether official immunity applies. Simply by commencing more than one proceeding against different parties involving more or less related issues, plaintiffs can generate the same sort of judicial economy showing that swayed the Court of Appeals. If defendants are entitled to claim official immunity, their right to do so should not be made to depend on whether plaintiff has chosen to bring one, two, or three separate lawsuits. Here, neither Blue Cross nor the Association is party to the second action, and if they are entitled to have the case against them dismissed, that right should not be denied merely because the second action with a different defendant may not be similarly resolved at the same time.

CONCLUSION

A writ of certiorari should be issued to review the judgment of the United States Court of Appeals for the Second Circuit.

Respectfully submitted,

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APPENDIX A

United States Court of Appeals

for the

Second Circuit

Nos. 703, 704 - August Term, 1985

(Argued February 3, 1986 Decided June 20, 1986)

Docket Nos. 85-6314, 85-6324

GROUP HEALTH INCORPORATED,

Plaintiff-Appellee,

— v. —

BLUE CROSS ASSOCIATION and BLUE SHIELD OF GREATER NEW YORK,

Defendants-Appellants.

UNITED STATES DEPARTMENT OF HEALTH and HUMAN SERVICES,

Intervenor-Defendant-Appellant.

Before:

FEINBERG, *Chief Judge*
VANGRAAFEILAND and CARDAMONE, *Circuit Judges*

Appeal from an order of the United States District Court for the Southern District of New York (Leisure, J.) by Blue Cross Association, Blue Cross/Blue Shield of Greater New York and the United States Department of Health and Human Services

that denied their motion for summary judgment on the grounds of absolute immunity in an action instituted by Group Health Incorporated. Because this is an appeal from a nonfinal order, we dismiss for lack of jurisdiction.

Dismissed.

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CARDAMONE, *Circuit Judge:*

This appeal concerns the relationship between a provider of insurance for medical and health services under Medicare and the fiscal intermediaries through which this provider elected to receive reimbursement from the federal government. One issue is whether or not the fiscal intermediaries were government agents acting within the scope of their authority. The government urges us to find that these intermediaries acted as government agents and are therefore entitled to absolute official immunity. Lurking in the background of this appeal are collateral questions regarding the viability of a Federal Torts Claims Act (FTCA) action begun by the provider in which it seeks to hold the government liable for the actions of the fiscal intermediaries, as government agents. Yet, in the FTCA suit, the government claims, interestingly enough, that the intermediaries are *not* its agents. Burrowing to the root of this tangle, it becomes clear that these contradictory claims are interrelated. Moreover, in their present posture the cases are too inchoate and tentative for us to undertake appellate jurisdiction.

Blue Cross Association (Association), Blue Cross/Blue Shield of Greater New York (Blue Cross), and the United States Department of Health and Human Services (HHS) appeal from an August 12, 1983 decision and order of the United States District Court for the Southern District of New York (Leisure, J.) denying their motion for summary judgment. The Association, Blue Cross and HHS (collectively, the defendants) argue that they are entitled to an immediate appeal from the denial of their claim of absolute immunity pursuant to the collateral order doctrine, *Cohen v. Beneficial Loan Corp.*, 337 U.S. 541 (1949), and that this Court has pendent appellate jurisdiction to review the other arguments advanced on appeal. For reasons to be discussed shortly, we do not believe the decision appealed from falls within that small class of cases encompassed by the collateral order doctrine and therefore dismiss this appeal.

I FACTUAL BACKGROUND

A. *Proceedings*

Group Health Incorporated (GHI) seeks damages from the Association and Blue Cross on causes of action sounding in negligence, misrepresentation and breach of the warranty of authority. GHI alleges it suffered a monetary loss as a result of Blue Cross' disallowance of Medicare reimbursement for interest incurred by Hillcrest General Hospital (Hillcrest), a private hospital which GHI owned from 1974-1980.

GHI commenced the instant action in New York State Supreme Court, New York County. After the Association and Blue Cross removed the action to the Southern District pursuant to 28 U.S.C. § 1442(a)(1) (1982), GHI moved to remand the case to state court. HHS then filed a motion to intervene as a defendant in the action. On June 13, 1984 the district court (Sweet, J.) denied GHI's motion to remand finding that Blue Cross' actions in denying the reimbursement for interest *were* taken under color of governmental authority. *Group Health Inc. v. Blue Cross Ass'n.* 587 F. Supp. 887, 889-91 (S.D.N.Y. 1984). Since Blue Cross acted as a fiscal intermediary on HHS' behalf, GHI's claim could be removed to federal court. It also granted HHS' motion for permissive intervention under Fed. R. Civ. P. 24(b) (2) and consolidated plaintiff GHI's separate proceeding against the United States. *Id.* at 891-93. In that action GHI alleges that the United States is liable under the FTCA for the negligent and wrongful acts of Blue Cross, the Association and HHS.

Following limited discovery, defendants moved on November 5, 1984 for summary judgment. Judge Leisure denied the motion and defendants appealed. GHI has moved to dismiss this appeal for lack of appellate jurisdiction.

B. *The Parties*

GHI is a not-for-profit health service corporation organized and operating pursuant to Article 43 of the New York Insurance Law, N.Y. Ins. L. §§ 4301 *et seq.* (McKinney 1985). Blue Cross

also is a not-for-profit corporation organized under the New York Insurance Law providing health insurance coverage to subscribers in the greater New York area. The Association is incorporated under the Illinois General Not-For-Profit Corporation Act and has a membership that includes Blue Cross as well as 67 other Blue Cross Plans operating throughout the country.

The Medicare program is a federally funded health insurance program for the aged and the disabled. 42 U.S.C. §§ 1395 *et seq.* (1982). It consists of two parts — A and B. Part A provides insurance coverage for hospital, related post-hospital, home health and hospice care. 42 U.S.C. § 1395c. The cost of providing Part A services is principally assumed by the Federal Hospital Insurance Trust Fund, which is funded by Social Security taxes. 42 U.S.C. § 1395i. Part A benefits may only be paid to providers of Medicare services. 42 U.S.C. § 1395f(a). Providers participating in Part A are prohibited from charging eligible patients for services covered by Medicare. 42 U.S.C. § 1395cc(a)(1)(A). Part B is an optional supplementary insurance program that covers payment of medical and health services not covered under Part A, for example, physicians' services. It is financed by payments from enrollees as well as funds provided by the federal government. 42 U.S.C. § 1395j.

GHI functioned as a carrier under Part B of the Medicare program and Hillcrest was a provider of Medicare services. Under 42 U.S.C. § 1395h(a) providers of inpatient services must choose to be reimbursed either by HHS or by a fiscal intermediary, a private organization under contract with HHS to serve as a conduit for reimbursement. The fiscal intermediary determines the amount of reinbursement due the provider and makes the reimbursement. It also resolves disputes concerning reimbursement decisions, 42 C.F.R §§ 421.100(e) & (f) (1985), and "serve[s] as a center for, and communicate[s] to providers, any information or instructions furnished to it by the Secretary, and serve[s] as a channel of communication from providers to the Secretary. . . ." 42 U.S.C. § 1395h(a). HHS may review the fiscal

intermediaries' initial reimbursement determinations. *See* 42 C.F.R. § 405.1885(b) (1985).

In this case the Association and Blue Cross served as fiscal intermediaries under Part A. With HHS' approval, the Association entered into a subcontract with Blue Cross, under the terms of which the Association delegated some of its assignments to Blue Cross. Pursuant to this subcontract and to Hillcrest's election, Blue Cross acted as Hillcrest's fiscal intermediary. The subject matter of this appeal involves reimbursement of Hillcrest under Part A during the six years it was owned by GHI.

C. *The Events*

In January 1973 GHI began exploring the possibility of acquiring a private hospital. GHI proposed to use its subscriber funds to acquire Hillcrest, and to accomplish this it was necessary to obtain the New York State Insurance Department's (Insurance Department) approval. In a letter dated June 22, 1973 GHI formally requested approval of the Insurance Department. On September 5, 1973 representatives of GHI and Blue Cross met to discuss the plans then underway to purchase Hillcrest. The following January GHI submitted to the Insurance Department an amended application to purchase Hillcrest which was approved on February 15, 1974.

Before GHI purchased Hillcrest, it requested Blue Cross' advice as to whether an interest return on the mortgage funds used to make the purchase would be included in the calculation of Hillcrest's Medicare and Blue Cross reimbursement rates. In a telephone conference on February 4, 1974, Mr. Ingram of Blue Cross informed Dr. Yaegar of GHI that "the Blue Cross Board of Directors did approve the interest return on investment." Blue Cross did not consult the Secretary or the Association at any time prior to ruling that this interest would be reimbursable for Medicaid purposes. On February 28, 1974 GHI purchased Hillcrest.

In a letter dated March 26, 1974 from William F. McMann, Assistant Commissioner of the New York State Health

Department, the Department rejected the proposed change in Blue Cross reimbursement because under Health Department Regulations, only proprietary organizations, and not Article 43 not-for-profit corporations, were entitled to a return on equity. The Department did conclude that, were GHI to make a loan from restricted funds to Hillcrest, interest paid on such loans would be a reimbursable cost. GHI informed Blue Cross by letter dated May 21, 1974 that it would give a $6 million mortgage to Hillcrest payable over 30 years at a nine percent rate to be repaid through constant monthly payments, with a standard annual repayment of $579,600. Blue Cross confirmed in a letter dated June 11, 1974, that these terms were acceptable for Medicare and Blue Cross reimbursement and that the interest on the loan, if paid according to schedule, would be included in calculating Blue Cross and Medicare reimbursement.

Hillcrest included the interest expense -- representing a 9 percent return on the funds used to purchase the hospital -- in its annual Medicare cost reports for fiscal years 1974 through 1980. In 1977 during its audit of Hillcrest's 1975 costs report, Blue Cross learned that Hillcrest had not paid any interest to GHI in 1974 or 1975. Blue Cross referred the matter to HHS which, through its Regional Medicare Director, notified Blue Cross on September 29, 1978 that the interest was not reimbursable under Medicare. HHS ruled that GHI's purchase of Hillcrest was an investment -- not a loan. Even were the transaction to be construed as a loan, HHS stated that the interest was not reimbursable because GHI and Hillcrest were related entities. Further, Hillcrest's failure to pay interest was additional evidence that GHI and Hillcrest were not dealing at arm's length. HHS concluded that it was "unable to understand how Blue Cross could have ruled that the 'loan' transaction [was] a reimbursable cost. . . . [A]uthoritative Medicare decisions can only come from written policy established by the Medicare Bureau or from consultation with this office." Blue Cross subsequently disallowed reimbursement for the interest payments.

Hillcrest requested a hearing before the Provider Reimbursement Review Board (PRRB) to appeal the interest disallowance for the 1974 through 1976 fiscal years. On September 19, 1980

the PRRB upheld the disallowance because GHI's purchase of Hillcrest did not constitute a loan from donor restricted funds, and the transaction between GHI and Hillcrest was not at arm's length. This decision became final on November 18, 1980 when the Secretary declined to affirm, reverse or modify. GHI brought an action against the Secretary in the Southern District of New York (Carter, J.), and that court granted the Secretary's motion for summary judgment. The court found the administrative decision supported by substantial evidence and held that the Secretary was not estopped from reversing Blue Cross' initial determination. We affirmed the district court's judgment in an unpublished order and the Supreme Court denied GHI's petition for certiorari.

II PROCEEDINGS

A. *The Complaint*

GHI asserts eight causes of action against Blue Cross and the Association; the first five pertain to reimbursement under the Medicare program and the last three to reimbursement under the Blue Cross reimbursement system. GHI alleges that Blue Cross was negligent and grossly negligent in (1) failing to consult the Secretary before representing that the interest was reimbursable; (2) falsely representing that Medicare would reimburse the interest; and (3) misrepresenting that it was authorized to act as the Secretary's agent in determining whether the interest was reimbursable under Medicare. Against the Association, GHI alleges that (4) it is responsible for Blue Cross' wrongs; and (5) it was negligent and grossly negligent in failing properly to supervise Blue Cross. The sixth through eighth claims allege that Blue Cross breached its agreement with GHI by refusing to include the rate of return in the reimbursement calculation and that Blue Cross is estopped from changing its position in that regard.

B. *District Court Decision*

Following limited discovery, Blue Cross and the Association moved for summary judgment on the first five claims arguing that GHI could not have relied on Blue Cross' decision that the interest was reimbursable because GHI purchased Hillcrest before

Blue Cross made such a written representation, and even if GHI did rely on Blue Cross' representation, such reliance did not, as a matter of law, give rise to a claim for relief under *Heckler v. Community Health Services*, 104 S. Ct. 2218 (1984). Finally, the Association and Blue Cross argued that these claims were barred by sovereign immunity. HHS joined in defendants' motion for summary judgment and raised the additional defense of official immunity.

The district court denied all aspects of defendants' motion for summary judgment on claims one through five. With respect to the sovereign immunity defense, it held that GHI's action was not against the United States and that a material question of fact existed as to whether Blue Cross' actions in interpreting the Medicare regulations were outside the scope of its authority. It applied a balancing test when it ruled that the Association and Blue Cross were not federal officials for immunity purposes, weighing the injustice caused by denying an injured plaintiff its remedy against the pressures placed upon an individual serving as a federal official, were that individual to be held liable for actions authorized by the government. Having concluded that these parties could not be "deemed" federal officials, the district court found it unnecessary to decide whether Blue Cross was acting within the scope of its authority. It further stated that even if the Association and Blue Cross could be considered federal officials, the existence of a question of fact concerning the scope of Blue Cross' authority precluded summary judgment. Finally, it rejected defendants' claim that, as a matter of law, GHI could not rely on its fiscal intermediary's misrepresentation. GHI's complaint was distinguished from *Heckler*, on the following grounds: (1) *Heckler* addressed the question of whether the government could be estopped from recovering funds expended by a health care provider in reliance on an incorrect interpretation of the Medicare regulations by a fiscal intermediary rather than the question of whether a health care provider could hold its fiscal intermediary liable for the intermediary's own negligence; (2) Unlike the provider in *Heckler*, GHI received a written statement from Blue Cross that the return would constitute a reimbursable cost; (3) A material issue of fact existed

as to whether it was reasonable for GHI to believe that Blue Cross had referred the matter to HHS.

III JURISDICTION

Ordinarily under 28 U.S.C. § 1291 (1982) denial of a motion for summary judgment is an unappealable order. *See Pacific Union Conf. of Seventh-Day Adventists v. Marshall*, 434 U.S. 1305, 1306 (1977); *New York v. Nuclear Regulatory Comm'n*, 550 F.2d 745, 759 (2d Cir. 1977). In *Cohen v. Beneficial Loan Corp.*, 337 U.S. at 546, the Supreme Court recognized that "[t]he effect of the statute is to disallow appeal from any decision which is tentative, informal or incomplete." Thus, we must first address the threshold question of whether there is jurisdiction to review the district court's order denying summary judgment based on some exception to § 1291 that permits an appeal from an interlocutory order.

In *Cohen*, the Supreme Court construed § 1291 as disallowing appeals from district court decisions that were nonfinal. *Id.* Even fully consummated decisions are not appealable when there are intermediate steps along the way to final judgment in which they will merge. For "[t]he purpose is to combine in one review all stages of the proceeding that effectively may be reviewed and corrected if and when final judgment results." *Id.* For an interlocutory order, such as the one before us, to be appealable it "must [(1)] conclusively determine the disputed question, [(2)] resolve an important issue completely separate from the merits of the action, and [(3)] be effectively unreviewable on appeal from a final judgment." *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 468 (1978); *Abney v. United States*, 431 U.S. 651, 658-59 (1977); *In re Agent Orange Product Liability Litigation*, 745 F.2d 161, 163 (2d Cir. 1984).

In *Coopers & Lybrand* the Supreme Court elaborated on the two distinct purposes served by the finality requirement of § 1291 and the statute's relationship to nonfinal orders that are appealable. First, § 1291 reflects a legislative decision that limiting appellate review to final orders "prevents the debilitating effect on judicial administration caused by piecemeal appeal disposition

of what is, in practical consequence, but a single controversy." 437 U.S. at 471 *quoting Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 170 (1974). Second, the Court emphasized that the final judgment rule preserves the proper balance between appellate and trial courts when disputed factual questions are involved. The Court reasoned:

> [A]llowing appeals of right from nonfinal orders that turn on the facts of a particular case thrusts appellate courts indiscriminately into the trial process and thus defeats one vital purpose of the final-judgment rule -- 'that of maintaining the appropriate relationship between the respective courts. . . . This goal, in the absence of most compelling reasons to the contrary, is very much worth preserving.'

Id. at 476.

Defendants argue that we have jurisdiction to review the district court's decision denying their motion for summary judgment on the absolute immunity defense. The Supreme Court, they point out, has held on several occasions that orders denying summary judgment on claims of absolute or qualified immunity are immediately appealable as collateral final orders. *See, e.g., Mitchell v. Forsyth*, 105 S. Ct. 2806, 2815-17 (1985) (Attorney General qualified immunity); *Nixon v. Fitzgerald*, 457 U.S. 731, 741-43 (1982) (Presidential immunity); *Helstoski v. Meanor*, 442 U.S. 500, 505-08 (1979) (Speech or Debate Clause); *Abney v. United States*, 431 U.S. at 659-62 (Double Jeopardy Clause).

Further, defendants contend that on appeal from a collateral final order, an appellate court has discretion to review other related nonappealable issues in the case "where '[t]here is sufficent overlap' " as defined by the doctrine of pendent appellate jurisdiction. *San Filippo v. U.S. Trust Co. of New York, Inc.*, 737 F.2d 246, 255 (2d Cir. 1984), *cert. denied*, 105 S. Ct. 1408 (1985) *quoting Sanders v. Levy*, 558 F.2d 636, 643 (2d Cir. 1976), *aff'd en banc*, 558 F.2d 646 (2d Cir. 1977), *rev'd on other grounds sub nom. Oppenheimer Fund, Inc. v. Sanders*, 437 U.S. 340

(1978). Therefore, according to defendants, we are not only vested with jurisdiction to review the denial of their claim of absolute immunity from suit, but also the related issue of whether GHI's misrepresentation claims are barred as a matter of law. We cannot agree.

Although defendants have alleged a nonfrivolous claim that fiscal intermediaries in the Medicare program are entitled to official immunity, *see San Filippo v. U.S. Trust Co. of New York, Inc.*, 737 F.2d at 254-55, this appeal must be dismissed. Defendants' claim of absolute immunity is not within "that small class which finally determine claims of right separable from, and collateral to, rights asserted in the action. . . ." *Cohen*, 337 U.S. at 546. We reach this conclusion for two reasons. First, the immunity question cannot be decided without addressing GHI's underlying claims on the merits, including such essential and disputed questions of fact as, for example, whether Blue Cross acted within the scope of its authority. At this stage in the litigation the immunity issues presented are not solely questions of law. *See Coopers & Lybrand*, 437 U.S. at 476 (disputed factual questions preclude appeal of nonfinal order); *Evans v. Dillahunty*, 711 F.2d 828, 830 (8th Cir. 1983) (motions for summary judgment based upon absolute or qualified immunity are appealable only if the underlying facts are undisputed and the immunity question is solely a question of law).

Second, to force GHI to litigate its claims against Blue Cross and the government separately when the claims and factual issues are "but a single controversy" results in an inefficient use of judicial resources. *Coopers & Lybrand v. Livesay*, 437 U.S. at 471 *quoting Eisen*, 417 U.S. at 170. Were we to find that Blue Cross and the Association were not immune, we might be simultaneously disposing of GHI's FTCA claims against the government, since the two defendants would not have been acting as government agents. Given that "the purpose [of § 1291] is to combine in one review all stages of the proceeding that effectively may be reviewed", *Cohen*, 337 U.S. at 546, judicial economy suggests that all of the closely intertwined immunity issues -- including those raised but not now before us under the

FTCA -- proceed together in the district court before the same judge. Assuming a trial, the jury and non-jury actions doubtless can be tried in one consolidated action with joint discovery and appropriate allocation of decision-making authority so as to result in one final judgment that will be effectively reviewable.

IV CONCLUSION

For the foregoing reasons, this appeal from a nonfinal interlocutory order denying summary judgment is dismissed for lack of appellate jurisdiction.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GROUP HEALTH INCORPORATED,

Plaintiff,

– against –

BLUE CROSS ASSOCIATION and
BLUE CROSS / BLUE SHIELD OF
GREATER NEW YORK,

Defendants,

– and –

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Intervenor-Defendant.

OPINION

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LEISURE, *District Judge:*

Plaintiff, Group Health Incorporated ("GHI"), seeks damages from defendants Blue Cross/Blue Shield of Greater New York ("Blue Cross") and Blue Cross and Blue Shield Association (the "Association") (collectively referred to as "Defendants"). GHI alleges harm suffered from disallowance of Medicare and Blue Cross reimbursement for certain costs allegedly incurred by Hillcrest General Hospital ("Hillcrest") in 1974-1980, the years GHI owned Hillcrest. GHI has asserted claims for negligence, misrepresentation and breach of warranty of authority against defendants Blue Cross and the Association. Blue Cross is sued in two capacities: as a private insurer, and as the fiscal intermediary for the federal government under the Medicare program. The Association is sued in its capacity as principal of Blue Cross acting as a fiscal intermediary.

Defendants have moved for an order granting them summary judgment pursuant to Fed. R. Civ. P. 56, on GHI's first through fifth claims, and an order dismissing the sixth through eighth claims, pursuant to Fed. R. Civ. P. 12(h)(3), on the basis that this Court lacks subject matter jurisdiction because GHI has failed to exhaust administrative remedies. For the reasons stated below, Defendants' summary judgment motion is denied and the Rule 12(h)(3) motion to dismiss is granted.

FACTUAL BACKGROUND

The sequence of events and many of the facts giving rise to the instant action have been described in two opinions previously "rendered by judges of this Court. *Group Health Inc. v. Schweiker*, No. 80 Civ. 6163 (S.D.N.Y. Mar. 22, 1982); *Group Health Inc. v. Blue Cross Ass'n*, 587 F. Supp. 887 (S.D.N.Y. 1984). Familiarity with these decisions is assumed. In the first opinion, Judge Carter affirmed the decision of the Provider Reimbursement Review Board ("PRRB") of the United States Department of Health and Human Services ("HHS"). The PRRB affirmed Blue Cross' decision to disallow reimbursement of certain interest expenses claimed by Hillcrest. The Court of Appeals, by an unpublished opinion, affirmed Judge Carter's decision. The Supreme Court denied GHI's petition for a writ of certiorari.

Thereafter GHI commenced this action in New York State Supreme Court. The complaint alleges that GHI is a not-for-profit corporation organized and existing under Article IX-C of the New York Insurance Law. That status subjects GHI's activities to regulation by New York's Superintendent of Insurance. When GHI proposed to expend subscriber funds to acquire Hillcrest, it was required to obtain prior Insurance Department approval. Such approval was granted conditionally upon whether a return on those funds would be included in the calculation of third-party reimbursement rates applicable to Hillcrest. Before GHI purchased Hillcrest in February 1974, the complaint alleges, GHI requested advice of Blue Cross as to whether a rate of return on the funds GHI used to purchase Hillcrest could be included in the calculation of Hillcrest's Medicare and Blue Cross reimbursement rates.

Blue Cross is also an Article IX-C corporation. Before it could amend its reimbursement formula to permit it to reimburse for a return on equity invested in a hospital by an Article IX-C corporation, it had to receive approval from the New York Insurance Department. Blue Cross, in a letter dated June 11, 1974, from Lawrence P. Cafasso, Director of Blue Cross Provider Reimbursement Division, informed GHI that a return of nine percent on the funds used to purchase Hillcrest would be included when calculating Hillcrest's Medicare and Blue Cross reimbursement rates. In 1979, at the insistence of HHS, Blue Cross disallowed the return for Medicare and Blue Cross reimbursement purposes and subsequently recouped from GHI any amounts previously paid to it that were attributable to the return on the invested funds.

GHI commenced this action in New York State Supreme Court. GHI's first claim alleges that Defendants were negligent in failing to consult HHS before rendering such advice to GHI. The second claim alleges that Blue Cross negligently and falsely represented that it had the authority to make such a determination. The third claim alleges that Blue Cross warranted it was authorized to act as the agent for HHS in determining whether the return would be reimbursable under the Medicare program. The fourth and fifth claims seek to hold the Association liable

for the acts and omissions of its agent and sub-contractor Blue Cross and for failing in its duty to properly supervise Blue Cross' activities. The sixth through eighth claims allege that Blue Cross breached its agreement with GHI by refusing to include the rate of return in the calculation of the Blue Cross reimbursement rate and that Blue Cross is estopped from changing its position in that regard.

Defendants removed the action to federal court and Judge Sweet denied GHI's motion to remand. Judge Sweet ruled that Blue Cross' actions were taken under color of governmental authority in that Blue Cross was acting as a fiscal intermediary on behalf of HHS and therefore the matter must be resolved in federal court. *Group Health Inc. v. Blue Cross Ass'n*, 587 F. Supp. at 891. In the same opinion Judge Sweet granted the motion of HHS to intervene under Fed. R. Civ. P. 24(b)(2) and to consolidate GHI's separate action against HHS.

GHI has pursued administrative review of its Blue Cross rates and the New York Department of Health has been conducting hearings on the matter.

MOTION FOR SUMMARY JUDGMENT

Defendants argue first that, as a matter of law, GHI was not entitled to rely on Blue Cross' advice concerning the calculation of the Medicare reimbursement rate, citing *Heckler v. Community Health Services of Crawford County, Inc.*, 104 S. Ct. 2218 (1984) (hereinafter *Community Health Services*). Second, GHI purchased Hillcrest before Blue Cross ruled in the Cafasso letter that Medicare reimbursement for the return on equity would be permitted. Consequently, no reliance on the alleged negligent misrepresentation was possible when GHI purchased Hillcrest. Third, Defendants argue, in the event GHI had relied justifiably on any representation of Blue Cross, GHI's claims against Defendants are barred under the principles of sovereign immunity. Defendants are sued in their capacity as fiscal intermediaries acting on behalf of HHS, and according to the Medicare regulations, HHS is the real party in interest. Fourth, HHS submitted a memorandum of law in support of Defendants' summary

judgment in which it argues that Defendants are protected by the doctrine of offical immunity.

Under the plain language of Rule 56(c), a court may grant a motion for summary judgment only if the moving party successfully demonstrates that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as matter of law. *See, e.g., Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970); *Patrick v. LeFevre*, 745 F.2d 153, 158 (2d Cir. 1984); *PPX Enterprises, Inc. v. Audiofidelity, Inc.*, 746 F.2d 120, 123 (2d Cir. 1984) (uncertainty about any material fact defeats the motion). Ambiguities must be viewed in the light most favorable to the party opposing summary judgment. *Project Release v. Prevost*, 722 F.2d 960, 968 (2d Cir. 1983). The burden of demonstrating the absence of any material fact genuinely in dispute rests on the moving party. *Adickes*, 398 U.S. at 157; *Heyman v. Commerce & Industry Insurance Co.*, 524 F.2d 1317, 1320 (2d Cir. 1975). Because a summary judgment is a "drastic device" it should be exercised with caution where, as here, one party has yet to complete pretrial discovery.[1] *See, e.g., Gary Plastic Packaging Corp. v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 756 F.2d 230, 236 (2d Cir. 1985); *National Life Insurance Co. v. Solomon*, 529 F.2d 59, 61 (2d Cir. 1975). Summary judgment, however, will not be denied merely because of conclusory allegations or denials by the opposing party. *JSP Agency, Inc. v. American Sugar Refining Co. of New York*, 752 F.2d 56, 59 (2d Cir. 1985); *SEC v. Research Automation Corp.*, 585 F.2d 31, 33 (2d Cir. 1978).

Was GHI Entitled To Rely On Blue Cross' Representations?

As summarized above, defendants argue that under the authority of *Community Health Services, supra*, a health care provider participating in Medicare is not entitled to rely upon the policy judgment of a mere conduit acting on behalf of the

[1] Discovery has been held in abeyance pending the Court's decision on the instant motion.

Secretary of HHS (hereinafter also collectively referred to as "HHS"). Under 42 U.S.C. § 1395h(a) a fiscal intermediary is required to provide consultative services to providers to enable them to establish and maintain fiscal records, to serve as a conduit for any information or instructions furnished to it by HHS and *to serve as a channel of communication from providers to HHS.*

The Supreme Court in *Community Health Services* stated that a health care provider has a duty to familiarize itself with the legal requirements for cost reimbursement and the nature of and limitations on the role of a fiscal intermediary. A fiscal intermediary, according to the relevant statutes and regulations and the reimbursement manual, acts merely as a conduit and may not resolve policy questions. 104 S. Ct. at 2226. The Court found that the health care provider in *Community Health Services* was satisfied with the policy judgment of a mere conduit and "made no attempt to have the questions resolved by [HHS]." *Id.* Consequently, the fiscal intermediary's advice was not given under circumstances conducive to reliance giving rise to estoppel against HHS. The reasonableness of the reliance was further undermined by the oral nature of the intermediary's advice. In the context of a complex program such as Medicare, in which the need for written records is manifest, reliance upon oral advice is unreasonable. *Id.*

The instant action is distinguishable from *Community Health Services* on several grounds. First, the issue there was whether the government could be estopped from recovering funds expended by a health care provider in reliance on an incorrect interpretation of the Medicare regulations given by a responsible government agent. *Id.* at 2220. As the Supreme Court stated, "the Government may not be estopped on the same terms as any other litigant." *Id.* at 2224. The instant issue is whether a health care provider can hold a fiscal intermediary liable for the intermediary's own negligence. *See, e.g., Rochester Methodist Hospital v. Travelers Ins. Co.*, 728 F.2d 1006 (8th Cir. 1984); *Hospital San Jorge, Inc. v. Blue Cross Ass'n*, Medicare & Medicaid Guide (CCH) ¶ 28,306 (D.P.R. 1976). No attempt is being made here to estop HHS from recoupment of

expenditures erroneously made. Indeed, GHI litigated that issue with HHS and lost.

Second, GHI received a *written* statement from Blue Cross that the return would consitute a reimbursable cost for purposes of Medicare. The fact that the letter was tendered subsequent to the February acquisition does not render speculative GHI's reliance on the Cafasso letter. GHI alleges that it could have restructured the financing or sold Hillcrest if it was informed in June 1974 that the rate of return on the funds used to purchase Hillcrest was not a reimbursable cost.

GHI's argument in this regard is factually supported by a letter from Lawrence O. Monin, First Deputy Superintendent, State of New York Insurance Department, addressed to Dr. George Melcher, President of GHI, dated February 15, 1974. In that letter Monin qualified the Insurance Department's approval of GHI's application to acquire Hillcrest on two conditions. First, that the proposed amendment to the Blue Cross Reimbursement Formula had to be certified by the Commissioner of Health and approved by the Superintendent of Insurance. Second, if, as actually occurred, such approvals were not forthcoming, GHI had to obtain a non-recourse mortgage in the minimum amount of $2,000,000 within "ninety days *after* acquisition of the hospital." (Emphasis added). In other words, if Hillcrest were not permitted to include in its prospective Blue Cross reimbursement rates the return on equity, GHI would have ninety days after the acquisition to restructure the financing. This certainly raises a reasonable inference that GHI could have restructured the financing again or even sold Hillcrest if Blue Cross had determined in June, 1974 that the rate of return was not a reimbursable cost for Medicare purposes.

Nevertheless, Defendants argue that all communications between the parties before the Cafasso letter related to Blue Cross reimbursement rates only. They claim that the Cafasso letter was the first time the topic of Medicare reimbursement rates was discussed. However, a letter dated March 26, 1974, from William F. McCann, Assistant Commissioner of the New York State Department of Health, to James C. Ingram, Division Vice

President, Provider Reimbursement of Blue Cross, states that "in establishing reimbursement rates for the hospital purchased by GHI, it is anticipated that the major third party payors will include their proportionate shares of interest paid to GHI subject to any specific third party formula limitations as to reasonableness and amount." Consequently, several months before sending the Cafasso letter, Blue Cross was aware that the reimbursement arrangement for which it was seeking approval would have to be acceptable to other third party payors, such as Medicare. Based upon this letter, it is certainly not beyond argument at this stage of the litigation that there was communication between GHI and Blue Cross concerning how the financing structure would be interpreted under the Medicare regulations.

The third ground on which *Community Health Services* may be distinguished concerns the issue of whether it was reasonable for GHI to rely on the advice of Blue Cross even though Blue Cross was only a conduit for communications between GHI and HHS. "It is undisputed that correct administrative practice required [Blue Cross] to refer [GHI's] inquiry to [HHS] for a definitive answer." *Community Health Services*, 104 S. Ct. at 2222. Unlike *Community Health Services*, where neither the provider nor the intermediary sought further advice when the question of interpretation initially arose, both parties in the instant case sought rulings from the New York State Departments of Insurance and Health concerning the contemplated arrangement. Such initial inquiry was logical, given the restrictions imposed by state law regarding the use of subscribers' funds. Such efforts raise a question of fact whether it was reasonable for GHI to believe that Blue Cross had likewise referred the question to HHS, especially in light of the written advise rendered by Blue Cross. "Written advice, like a written judicial opinion, requires its author to reflect about the nature of the advice that is given . . . , and subjects that advice to the possibility of review, criticism and reexamination." *Id.* at 2227. In this regard, Blue Cross did not consult with HHS as to whether the arrangement would pass scrutiny under Medicare's related party regulations[2] because "the

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[2] 42 C.F.R. § 405.419(b)&(c) (1979).

whole transaction had been thoroughly reviewed and approved by two different agencies of the state government." Testimony of James C. Ingram, PRRB Hearing, June 10, 1980, at 0216-17. This issue is significant because 42 U.S.C. § 1395h(a)(2)(A) expressly states that intermediaries are to "serve as a channel of communication from providers to the Secretary."

The cumulative effect of these facts and circumstances is to distinguish the instant case from *Community Health Services* and raise material issues of fact. GHI is not seeking to estop HHS from recovering money erroneously paid out. Blue Cross rendered written advice to GHI that the arrangement was acceptable under Medicare's regulations. Finally, GHI may have arranged for alternate financing had Blue Cross indicated in June, 1974 that Medicare would not reimburse Hillcrest for the return on its investment.[3]

Sovereign Immunity

Next, defendants argue that because fiscal intermediaries act on behalf of HHS in performing their contractual undertakings, HHS is the real party in interest in this lawsuit. 42 C.F.R. § 421.5(b)(1984).[4] The fiscal intermediary, Blue Cross,

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[3] Defendants further argue that GHI failed to adhere to the terms of the approved arrangement by not carrying the investment on its books as a mortgage-loan transaction and not enforcing its right to interest payments from Hillcrest. They claim this precludes GHI from holding Defendants responsible for GHI's losses. Significant in this regard is the September 29, 1978 letter from Jacqueline G. Wilson, Regional Medicare Director, to Peter L. Hutchins, Senior Vice-President-Finance of Blue Cross. In this letter, Ms. Wilson states that the failure to pay interest was "merely additional evidence" that the arrangement was not arms-length, thereby making the return on investment a non-reimbursable cost. Ms. Wilson concluded that investment a non-reimbursable cost. Ms. Wilson concluded that Medicare was "unable to understand how Blue Cross could have ruled that the 'loan' transaction is a reimbursable cost." In other words, it was the relationship between GHI and Hillcrest that disqualified the transaction, not the failure to pay interest.

[4] This position appears to be a variation of the so-called government contractor defense to liability for injuries to another caused in the course of performing work on behalf of the government. *See Yearsley v. W.A. Ross Const. Co.*, 309

(Footnote Continued)

therefore, is wrapped in the protective mantle of the government's sovereign immunity, barring GHI's suit. The cases that Defendants have cited in support of this position[5] provide little guidance in this action, however, because, as stated by the court in *Rochester Methodist Hospital v. Travelers Ins. Co.*, 728 F.2d 1006 (8th Cir. 1984), "in none of these cases was there proof that the intermediary acted beyond the scope of its authority." 728 F.2d at 1015. *See also, Hospital San Jorge, Inc. v. Blue Cross Ass'n*, Medicare & Medicaid Guid (CCH) ¶ 28,306, at 9074-75 (D.P.R. 1976). Also, in each of the cases cited by Defendants, the fiscal intermediary disallowed a claim for reimbursement. None involved advice rendered prospectively *before* a claim for reimbursement was made as Blue Cross did in the instant action.

Plaintiff alleges that Defendants engaged in tortious activity and acted beyond the scope of their authority. According to the Supreme Court, a fiscal intermediary has neither actual nor apparent authority to render an interpretation of the Medicare regulations. *Community Health Services*, 104 S. Ct. at 2226 n.21. Where the law limits a government agent's powers "his actions beyond those limitations are considered individual and not sovereign actions." *Larson v. Domestic & Foreign Corp.*, 337 U.S. 682, 689 (1949). Consequently, a material question of fact exists as to whether Blue Cross was acting within the scope

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U.S. 18 (1940), *cert. denied*, 374 U.S. 827 (1963). In *Yearsley* the Supreme Court stated that a government contractor can be held liable for conduct causing injury to another if it is found "that he exceeded his authority." *Id.* at 21. *Accord Ove Gustavsson Contracting Co. v. Floete*, 299 F.2d 655, 660 (2d Cir. 1962). *See generally In re "Agent Orange" Product Liability Litigation*, 506 F. Supp. 762, 792-94 (E.D.N.Y.), *rev'd on other grounds*, 635 F.2d 987 (2d Cir. 1980) *cert. denied*, 454 U.S. 1128 (1981).

[5] *Peterson v. Weinberger*, 508 F.2d 45 (5th Cir.), *cert. denied*, 423 U.S. 830 (1975); *Matranga v. Travelers Ins. Co.*, 563 F.2d 677 (5th Cir. 1977); *Pine View Gardens, Inc. v. Mutual of Omaha Ins. Co.*, 485 F.2d 1073, 1074-75 (D.C. Cir. 1973); *Arzt v. Blue Cross and Blue Shield of Greater New York*, No. 78 Civ. 5723 (S.D.N.Y. Oct. 29, 1982); *Vanderberg v. Carter*, 523 F. Supp. 279 (N.D. Ga. 1981), *aff'd*, 691 F.2d 510 (11th Cir. 1982); *Johnson v. Johnson*, 332 F. Supp. 510, 511 (E.D. Pa. 1971); *Kuenstler v. Occidental Life Ins. Co.*, 292 F. Supp. 532, 537 (C.D. Cal. 1968).

of its authority in giving the advice to GHI. *Slotkin v. Citizens Casualty Co. of New York*, 614 F.2d 301, 317 (2d Cir.), *cert. denied*, 449 U.S. 981 (1980).

The papers presented to the Court on this motion indicate there is merit to GHI's allegations in this regard. During the time that GHI acquired Hillcrest, Blue Cross itself was interested in buying hospitals with subscriber's funds. *See* Testimony of James C. Ingram, PRRB hearing, June 10, 1980, at 0210-11, 0222, 0272. An August 30, 1978 report prepared by the Medicare Office of Program Integrity commented on the actions of Blue Cross as follows:

> The parties involved in making the decision [Blue Cross and the New York State Departments of Health and Insurance] appeared to over extend their authority and in fact may have acted improperly in this situation.
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> * * *
>
> By ruling on a complex Medicare reimbursement situation without consulting the Medicare Bureau, Blue Cross may have put its intermediary role second to its own private plan's best interest. This is evidenced by the fact that at the time of the Hillcrest purchase, Blue Cross was interested in purchasing hospitals itself. Blue Cross may have taken an active role and even bent its interpretations of the reimbursement regulations to suit a situation that would act as a catalyst for a reimbursement ruling it could benefit from in the future.

Judge Carter referred to this possible conflict of interest when he denied GHI's application to overturn the decision of the PRRB, stating that "the intermediary advise[d] the provider in large part from the perspective of a competitor seeking ways to achieve the agreed upon result for itself. . . ." *Group Health Inc. v. Schweiker*, No. 80 Civ. 6163, slip op. at 11 (S.D.N.Y. Mar. 22, 1982).

Where there are specific allegations that Blue Cross did not act on direct instructions from HHS but rather acted beyond the

scope of its authority, summary judgment on the sovereign immunity claim is inappropriate. The effect of such allegations in the context of such a motion was recognized and aptly described by Judge Haight in *Arzt v. Blue Cross & Blue Shield of Greater New York*, No. 78 Civ. 5723 (S.D.N.Y. Oct. 29, 1982) when he granted a summary judgment to Blue Cross on a claim that Blue Cross participated in a conspiracy to force a healty care provider out of business. Judge Haight stated:

> [T]he only reasonable conclusion that can be drawn is that Blue Cross, as fiscal intermediary, is being sued for actions it took because of its statutory powers as a fiscal intermediary, *and not because of any alleged negligence in failing to exercise properly those duties.* The acts upon which Blue Cross's liability is predicated are the withholding of Medicare payments. . . .

Id., slip op. at 28 (emphasis added).

Notwithstanding the allegations that Blue Cross acted beyond the scope of its authority, Defendants and HHS argue that sovereign immunity applies in any event because an indemnity agreement would require any judgment against Defendants to be paid ultimately by HHS. This argument is based upon the principle that a lawsuit is against the government regardless of who is named as a defendant if the relief sought would be paid from the public treasury. *See, e.g., Stafford v. Briggs*, 444 U.S. 527, 542 n.10 (1980); *Dugan v. Rank*, 372 U.S. 609, 620 (1963); *Falls Riverway Realty, Inc. v. City of Niagara Falls*, 754 F.2d 49, 55-56 (2d Cir. 1985).

Pursuant to 42 C.F.R. § 421.5(b), HHS has agreed to indemnify Defendants and pay any judgments, except those rendered for criminal conduct, fraud or gross negligence against the Association or Blue Cross resulting from the performance of their contractual obligations. Thus, if Defendants are found liable in this action, HHS will ultimately pay. According to the principle set forth above, this would trigger the government's sovereign immunity.

While this argument has some facial appeal, it has been rejected by courts because an indemnity agreement between the government and its agents does not affect the rights of third parties. *Rochester Methodist Hospital*, 728 F.2d at 1012-14 (citing *Brady v. Roosevelt Steamship Co.*, 317 U.S. 575, 583 (1943) ("The rights of principal and agent *inter se* are not the measure of the rights of third persons against either of them for their torts.")). "A government may not manufacture immunity for its employees [and contractors] by agreeing to indemnify them." *Spruytte v. Walters*, 753 F.2d 498, 512 n.6 (6th Cir. 1985). *Accord Demery v. Kupperman*, 735 F.2d 1139, 1146-47 (9th Cir. 1984), *cert. denied*, 105 S. Ct. 810 (1985); *Downing v. Williams*, 624 F.2d 612, 626 (5th Cir. 1980), *vacated on other grounds*, 645 F.2d 1226 (5th Cir. 1981); *Foster v. Day & Zimmermann, Inc.*, 502 F.2d 867, 875 (8th Cir. 1974); *Whitaker v. Harvell-Kilgore Corp.*, 418 F.2d 1010, 1014 (5th Cir. 1969). *Cf.* L. Tribe, *American Constitutional Law* § 3-35, at 132-33 n.22 (1978). The very existence of an indemnity agreement undercuts the argument that as a consequence intermediaries are protected by sovereign immunity. "[I]f sovereign immunity was intended . . . there would be no necessity of an indemnity agreement. . . ." *Whitaker*, 418 F.2d at 1014.

Based upon the foregoing, GHI's claims against Defendants are not barred by sovereign immunity.

Official Immunity

HHS argues in its memorandum of law in support of Defendants' summary judgment motion that GHI's claims are barred under the doctrine of official immunity. The official immunity doctrine provides that federal officials are absolutely immune from liability for common-law torts allegedly committed in the performance of official duties that require the exercise of judgment or discretion. *Barr v. Matteo*, 360 U.S. 564 (1959). The purpose of this judicially created rule is to ensure that government officials are able to exercise their duties free from the fear of damage suits arising out of acts done in the course of those duties. Government officials would be free of the threat of lawsuits "which might appreciably inhibit the fearless, vigorous,

and effective administration of policies of government." *Id.* at 571.

Official immunity has been held to protect all executive officials regardless of rank, provided the official was acting within the outer limits of his authority and the act involved the exercise of judgment or discretion. *Id.* at 572-73.

> The privilege is not a badge or emolument of exalted office, but an expression of a policy designed to aid in the effective functioning of government. The complexities and magnitude of governmental activity have become so great that there must of necessity be a delegation and redelegation of authority as to many functions, and we cannot say that these functions become less important simply because they are exercised by officers of lower rank in the executive hierarchy.

Id. (footnote omitted). The courts have applied the Supreme Court's broad formulation of the doctrine to the extent that is has been held to apply to a nurse supervisor at a Veterans Administration hospital who was sued for writing an allegedly libelous incident report. *Newkirk v. Allen*, 552 F. Supp. 8 (S.D.N.Y. 1982). This result was foretold by Justice Brennan in his dissenting opinion in *Barr v. Matteo* when he stated that the approach set forth in Justice Harlan's plurality opinion would "clothe with immunity the most obscure subforeman on an arsenal production line who has been delegated authority to hire and fire and who maliciously defames one he discharges." 360 U.S. at 587. *See also* Gray, *Private Wrongs of Public Servants*, 47 Cal. L. Rev. 303, 337 (1959) (hereinafter *Private Wrongs*).

Cases where claims of official immunity have been upheld involved defamation, false arrest or imprisonment, and malicious prosecution. *See Norton v. McShane*, 332 F.2d 855, 859-60 n.5 (5th Cir. 1964), *cert. denied*, 380 U.S. 981 (1965); *Private Wrongs*, 47 Cal. L. Rev. at 337-38 n.223. The doctrine has been held to apply when negligent misrepresentation has been alleged. *See, e.g., Claus v. Gyorkey*, 674 F.2d 427 (5th Cir. 1982);

Sowders v. Damron, 457 F.2d 1182 (10th Cir. 1972). The application of the doctrine to persons performing work at so many levels of government and in such far ranging circumstances has led one commentator to suggest that the growth of the immunity rule is due to "its convenience as a form of judicial shorthand to dispose, at the pleading stage, cases which obviously have little merit." *Private Wrongs*, 47 Cal. L. Rev. at 338. *Cf.* Annot., 9 A.L.R.3d 382, 387 (1966).

HHS argues that since Blue Cross and the Association were acting as agents of HHS in the role of Medicare fiscal intermediaries they should be deemed federal officials for purposes of immunity. Such private entities performing federal functions as agents of the government therefore should be protected. GHI, for its part, contends that it is incorrect to protect Blue Cross and the Association with official immunity.

According to the balancing test that is applied to determine whether extension of immunity is appropriate, the court must weigh the injustice that results from denying a plaintiff a remedy for its injury against the pressures that would be placed upon an individual serving as a federal official if that individual could be held liable for monetary damages for actions authorized by the government. *Barr v. Matteo*, 360 U.S. at 565, 570-71. GHI contends that the rationale behind the official immunity rule does not apply in this case. The Defendants are large private insurance corporations which contracted to perform services for the Department. Defending damage lawsuits arising out of their roles as fiscal intermediaries would not be any different than defending lawsuits in connection with their own hospital insurance programs. GHI argues that, since defending those suits does not divert time that would otherwise be devoted to government service, the same considerations necessarily apply to the defense of lawsuits arising out of the performance of duties in the Medicare program. Likewise, the cost of defending lawsuits are a cost of doing business and are figured into the prices charged and the amounts bid for contracts.

The case law indicates that it is appropriate to consider a private person a government official if the conduct at issue is

instigated and directed by federal officers. *Reuber v. United States*, 750 F.2d 1039, 1063-64 (D.C. Cir. 1984) (Bork, J., concurring). *Cf. Falls Riverway Realty*, 754 F.2d at 57 (city agency an agent "only if the United States supervised the day-to-day operations"). In *Blum v. Campbell*, 355 F. Supp. 1220 (D. Md. 1972), a defamation action, the manager of an apartment complex under contract to the Federal Housing Administration was deemed entitled to official immunity. The contract with FHA provided that the day-to-day administrative details of operation would be under supervision of the local FHA office. The court found that the FHA closely supervised the company's activities during the period involved and the company "did no more than carry out FHA instructions." *Id.* at 1224. As a result, the defendants "were acting as agents under the direct supervision and control of the FHA and not as independent contractors." *Id.*

In *Becker v. Philco Corp.*, 372 F.2d 771 (4th Cir.), *cert. denied*, 389 U.S. 979 (1967), a defense contractor filed a report with the government which resulted in suspension of plaintiff's security clearances. The defense contract required the company to keep the government advised of suspected security risks. The court held that the communications were privileged under *Barr v. Matteo* because the contractual requirement transformed the company into an agent of the government. 372 F.2d at 774-75.

In *McManus v. McCarthy*, 586 F. Supp. 302 (S.D.N.Y. 1984), a libel action, cadets at the Merchant Marine Academy were deemed to be performing a federal function under the control of federal officers because they acted under the direct supervision and control of the Academy's superior officers, who are federal employees. *Id.* at 305. Likewise, in *Loguirato v. Action*, 490 F. Supp. 84 (D.D.C. 1980), medical examiners who acted under Peace Corps direction and control were protected by official immunity.

In *Bushman v. Seiler*, 755 F.2d 653 (8th Cir. 1985), the court extended official immunity to a consultant for a Medicare carrier sued for libel due to a report he filed at the carrier's request as part of an audit investigation. The court recognized that Medicare intermediaries "can" be governmental agents for

immunity purposes and that the defendant's relationship to the Medicare program "may" shield him with official immunity. *Id.* at 655. The audit was conducted pursuant to 42 C.F.R. § 421.200(e) and the report was for internal use only. Although Seiler's link to the federal government was indirect, the court held that "under the circumstances of this case, official status should be extended to Seiler as a consultant to a Medicare carrier." *Id.*

Bushman would appear to provide support for the contentions of HHS. But important considerations not present in this case entered into the court's decision. The court acted on "a recognition that public criticism of government operation should be encouraged." *Id.* at 656. Unless such communications are privileged, government contractors who are aware of real or imaginary shortcomings in connection with government activity would be dissuaded from communicating their concerns to the proper authority. *Id.* Thus, in *Bradley v. Computer Sciences Corp.*, 643 F.2d 1029 (4th Cir.), *cert. denied*, 454 U.S. 940 (1981), the court held that a letter written by a private corporation to the Defense Communications Agency about the conduct of one of the agency's employees was deemed qualifiedly privileged under the petition clause of the First Amendment. *Id.* at 1033. Although the defendant was a government contractor, the court did not extend it official immunity, while it did extend such protection to the government defendants.[6]

These cases demonstrate that a court must scrutinize the particular conduct at issue and weigh whether it is appropriate under the circumstances to protect the private party. In each case where a government contractor was involved such status was not significant in the outcome. Rather, the circumstances surrounding the particular conduct at issue were important to the determination that official immunity would apply.

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[6] In *Bushman* the Eighth Circuit extended official immunity to the defendant rather than consider whether the defense of sovereign immunity applied. 755 F.2d at 655 n.2 (citing *Rochester Methodist Hospital*, 728 F.2d at 1012-16).

Turning to the facts of this case, it is apparent that the defendants cannot be considered government officials. The conduct complained of was not undertaken at the instigation and direction of the government. To the contrary, Blue Cross acted wholly on its own, without direction or guidance from HHS. Although 42 C.F.R. § 421.5(b) provides that intermediaries act on behalf of HHS, that regulation does not elevate the intermediaries to the status of government officials so that they would be immune for their own tortious conduct. *Cf. Rochester Methodist Hospital*, 728 F.2d at 1014.

If the intermediaries were to be endowed with official immunity, Congress was capable of expressly providing for such status. The legislative history indicates that Congress deemed it appropriate to permit the government to indemnify the intermediaries under certain circumstances, but it no where provides that the intermediaries shall enjoy official or sovereign immunity. *See* S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 1995 ("the Government would be expected to safeguard the interests of his contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secretary."). Instead, Congress recognized that the intermediaries are independent contractors and are liable for their own torts and authorized the HHS to enter into indemnity agreements. It is significant that the agreements do not extend to judgments for criminal conduct, fraud or gross negligence resulting from the performance of the intermediaries' obligations, while official immunity confers an absolute immunity without regard to whether the conduct is willful or malicious. *See, e.g., Barr v. Matteo*, 360 U.S. at 571 (quoting *Gregoire v. Biddle*, 177 F.2d 579, 581 (2d Cir. 1949), *cert. denied*, 339 U.S. 949 (1950)). And, as was discussed with reference to Defendants' sovereign immunity claim, the existence of an indemnity agreement does not affect the rights of third parties.

Having determined that Defendants cannot be deemed government officials, it is unnecessary to decide whether Blue

Cross was acting within the scope of its authority. Because a factual dispute exists with respect to this important issue it is likely that a decision on this issue would have to be deferred in any event, pending further factual development as to the exact scope of the authority of the fiscal intermediary. *See, e.g., Expeditions Unlimited Aquatic Enterprises, Inc. v. Smithsonian Institution*, 566 F.2d 289, 295 (D.C. Cir. 1977), *cert. denied*, 438 U.S. 915 (1978); *Kletschka v. Driver*, 411 F.2d 436, 449 (2d Cir. 1969) ("A plea of official immunity cannot be sustained until a court has knowledge of the exact nature of the defendants' actions and the precise scope of their official duties."); *Liquori v. Alexander*, 495 F. Supp. 641, 648 (S.D.N.Y. 1980) (existence of factual dispute as to scope of authority requires further factual development).

Liability of the Association

Defendants' motion for summary judgment on GHI's claim against the Association must be considered in the context of the facts, circumstances and legal principles discussed above with respect to Blue Cross. In addition, the Association may bear responsibility for the actions of Blue Cross in light of the Association's policy which discouraged Blue Cross from approaching HHS directly for rulings on reimbursement matters. Testimony of James C. Ingram, PRRB Hearing, June 10, 1980, at 0227.

Accordingly, Defendants' motion for summary judgment on the first five claims is hereby denied.

RULE 12(h)(3) MOTION

Blue Cross seeks to dismiss, pursuant to Fed. R. Civ. P. 12(h)(3),[7] GHI's sixth through eighth claims, which allege breach of contract against Blue Cross in its capacity as a private insurer. The basis for this motion if GHI has not exhausted the administrative procedures set forth by state law for review of Blue Cross reimbursement rates. Rules and regulations promulgated by the New York Department of Health provide for appeals to the Commissioner of Health by an individual hospital which seeks to challenge a certified rate. 10 N.Y.C.R.R. § 86-1.17(c) (1983).

GHI has pursued administrative review of its Blue Cross rates according to the procedures set forth in the Blue Cross formula and the regulations. The Department of Health administrative law judge conducting hearings on the matter has set forth the following as the "issues to be determined":

> What were the precise terms of the agreement between the State (representing the Departments of Health and Insurance plus Blue Cross and Blue Shield) and Hillcrest/GHI? Assuming, as was admitted, the agreement was to treat the Hillcrest/GHI investment as a loan, what if any, indicia of a loan had to be carried out by Hillcrest/GHI to consummate the agreement? . . . [T]he ultimate question is this: . . . . can the State, by agreement, pay Medicaid funds it would not ordinarily have to pay under the statutes, regulations and existing guidelines?

The factual issues being presented at the administrative level, as set forth above, are similar to those raised by GHI's sixth through eighth claims.

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[7] Rule 12(h)(3) provides:

Whenever it appears by suggestion of the parties or otherwise that the court lacks jurisdiction of the subject matter, the court shall dismiss the action.

The doctrine of exhaustion of administrative remedies is a "long settled rule of judicial administration that no one is entitled to judicial relief for a supposed or threatened injury until the prescribed administrative remedy has been exhausted." *Myers v. Bethlehem Shipbuilding Corp.*, 303 U.S. 41, 50-51 (1938). A primary purpose for the rule is "the avoidance of premature interruption of the administrative process." *McKart v. United States*, 395 U.S. 185, 193 (1969). Other purposes include permitting the agency best suited and possessing the necessary expertise to determine the questions at issue, permitting such agency to develop the necessary factual background upon which decisions should be based and conserving judicial resources. *Id.* at 194-95. The rule, which has been considered a limit of the court's subject matter jurisdiction, *White v. Shull*, 520 F. Supp. 11, 13 (S.D.N.Y. 1981); *Fairchild, Arabatzis & Smith, Inc. v. Sackheim*, 451 F. Supp. 1181, 1184 (S.D.N.Y. 1978), has been applied to actions similar to this one begun by hospitals challenging decisions on reimbursement rates. *Sunrest Nursing Home, Inc. v. Whalen*, 99 A.D.2d 206, 473 N.Y.S.2d 34 (3d Dep't 1984); *Arnot-Ogden Memorial Hospital v. Blue Cross of Central New York, Inc.*, 92 A.D.2d 629, 459 N.Y.S.2d 950 (3d Dep't 1983); *Crouse-Irving Memorial Hospital v. Axelrod*, 82 A.D.2d 83, 442 N.Y.S.2d 338 (4th Dep't 1981).

Blue Cross argues that these interests would be served here if GHI exhausted its administrative rights before proceeding in court. First, there is an appeal of Blue Cross' reimbursement decision pending before a Department of Health administrative judge, whose decision will be reviewed by the Commissioner of Health. Requiring exhaustion would avoid premature interruption of the administrative process. Second, the state agency will be able to develop the factual background upon which the ultimate decision will be based. Third, the state agency is best suited and possesses the necessary expertise to determine the questions raised by GHI's appeal of Blue Cross' decision. Fourth, the controversy may be resolved in the administrative process and judicial intervention would be unnecessary.

GHI acknowledges that these general principles apply herein, but argues that the issues underlying the three claims for relief

against Blue Cross are essentially contractual. As such, the prescribed administrative remedies need not be utilized or exhausted. *See, e.g., Mary Imogene Bassett Hospital v. Hospital Plan, Inc.*, 89 A.D.2d 240, 455 N.Y.S.2d 416 (4th Dep't 1982). Resort to administrative remedies was not required in the *Bassett Hospital* case, however, because the defendant's contract breach foreclosed the hospital's right to pursue its administrative remedies. *Id.* at 244, 455 N.Y.S.2d at 419. *See Arnot-Ogden Memorial Hospital*, 92 A.D.2d at 630, 459 N.Y.S.2d at 952. No such situation is presented here.

Due to plaintiff's failure to exhaust its administrative remedies, subject matter jurisdiction is lacking. Accordingly, GHI's sixth through eighth claims are hereby dismissed pursuant to Rule 12(h)(3).

CONCLUSION

Defendants' summary judgment motion to dismiss GHI's first five claims is denied. Defendants' motion to dismiss GHI's sixth through eighth claims for lack of subject matter jurisdiction is granted.

SO ORDERED

Dated: New York, New York
August 12, 1985

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U.S.D.J

APPENDIX C

Statement Pursuant to Rule 28.1

Petitioners Blue Cross Association and Blue Cross/Blue Shield of Greater New York changed their names to Blue Cross and Blue Shield Association and Empire Blue Cross and Blue Shield, respectively.

Blue Cross and Blue Shield Association is affiliated with the following entity:

BCS Financial Corp.

Empire Blue Cross and Blue Shield is affiliated with the following entities:

Access America, Inc.
BCS Financial Corp.
Dental Network of America, Inc.
Health Information Reporting Company
Health Plans Capital Service Corp.
System Re Ltd.